Medicare: History of Provisions

Act [*]	Insured Status
	Entitlement to Hospital Insurance Benefits
1965	Any individual aged 65 or older entitled to monthly benefits under the Social Security or Railroad Retirement program, or aged 65 before 1968, or 3 quarters of coverage (QC) after 1965 and before attainment of age 65.
1967	Or 3 QC for each year after 1966 and before attainment of age 65.
1972	Any disabled individual, under age 65, entitled to monthly disability benefits for 24 consecutive months under the Social Security or Railroad Retirement program (excludes spouses and children of disabled individuals). Any individual under age 65 who has end stage renal disease and who is either fully or currently insured, or is entitled to monthly benefits under the Social Security or Railroad Retirement program or is the spouse or dependent child of such an insured individual or beneficiary. Entitlement begins on the first day of the third month following the initiation of a course of renal dialysis and ends with the 12th month following the month in which either the dialysis terminates or the individual has a renal transplant.
	Any individual aged 65 or older enrolled in the SMI program who is not otherwise entitled to HI benefits, upon voluntary participation with payment of hospital insurance premium.
1980	Any individual who would be entitled to monthly benefits under the Social Security or Railroad Retirement program if application were made.
	Any disabled individual under age 65 entitled to monthly disability benefits for a total of 24 months, not necessarily consecutive, under the Social Security or Railroad Retirement program.
	Medicare coverage extended for up to 36 months for disabled individuals whose disability continues, but whose monthly benefit ceased because they engaged in substantial gainful activity.
	Second waiting period eliminated if a former disabled-worker beneficiary becomes entitled again within 5 years (7 years for disabled widows and widowers and disabled children aged 18 or older).
1982	Federal employees covered under HI based on QC for earnings as federal employees and/or based on deemed QC for earnings as federal employees before 1983.
1983	Employees of nonprofit organizations, effective Jan. 1, 1984.
1985	Premium-paying individuals who do not purchase Part A coverage within a specific time after becoming eligible because of age are subject to a 10-percent penalty for each 12 months they are late in enrolling. There is a cutoff on the length of time these individuals will have to pay an enrollment penalty. The 10-percent premium penalty would be limited to twice the number of years enrollment was delayed. Therefore, if enrollment were delayed 1 year, the penalty would be assessed for 2 years. Individuals in this category and already enrolled will have the length of time the higher premium was paid credited to them.
1986	Mandatory coverage—Hospital Insurance (Part A) program only—provided to state and local government employees not covered under Social Security and hired after Mar. 31, 1986.
1987	Second waiting period eliminated if a former disabled beneficiary becomes entitled again (no time limit).

[*] Act refers to legislation enacted in the year shown.

Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1989 Disabled individuals under age 65 who are no longer entitled to Social Security disability benefits because their earnings exceeded the substantial gainful activity level have the option to purchase Medicare coverage by paying the HI and SMI premiums.

Entitlement to Supplementary Medical Insurance Benefits

1965 Any U.S. resident (citizen or lawfully admitted alien with 5 years continuous residence) aged 65 or older or any individual entitled to HI benefits upon voluntary participation with payment of SMI premium.

1972 Any individual under age 65 entitled to HI benefits, upon voluntary participation with payment of SMI premium.

1984 For calculating the amount of premium surcharge for individuals from age 65 up to age 70 not previously enrolled in Medicare, the number of years of an individual's employer group health insurance will not be taken into account.

1987 Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

Medicare Benefits

HI and SMI

Requires that Medicare be secondary payer to benefits provided by liability insurance policies or under no-fault insurance.

1981 Requires that Medicare be secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely due to end-stage renal disease (ESRD) for up to 12 months.

1982 For workers and their spouses aged 65-69, Medicare is the secondary payer when benefits are provided under an employer-based group health plan (applicable to employers with 20 or more employees who sponsor or contribute to the group plan).

Health maintenance organizations (HMOs) will be covered as providers of benefits. The Secretary of HHS must certify the prospective payment mechanism for HMOs before implementation.

1984 Medicare secondary payer provisions are extended to spouses aged 65-69 of workers under age 65 whose employer-based group health plan covers such spouses.

For health maintenance organizations (HMOs), includes medical and other health services furnished by clinical psychologists.

1985 Provides payment for liver transplant services.

1986 Extends the working age secondary payer provision to cover workers and their spouses beyond the age of 69.

For HMOs that offered organ transplants as a basic health service on Apr. 15, 1985, such services may be offered from Oct. 1, 1985, through Apr. 1, 1988.

For disabled individuals who are covered by employer-based health plans (with at least 100 employees), Medicare is the secondary payer, effective for 1987-91.

1987 Requires health maintenance organizations/competitive medical plans that cease to contract with Medicare to provide or arrange supplemental coverage of benefits related to preexisting conditions for the lesser of 6 months or the duration of an exclusion period.

Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

Clarifies that the secondary payer provision for disabled individuals covered under employer-based health plans for employers with at least 500 employees applies to employers that are government entities.

1990 Requires that Medicare be the secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely due to ESRD for up to 18 months (extended from 12 months), effective Feb. 1, 1991, to Jan. 1, 1996.

The secondary payer provision for disabled beneficiaries covered under large employer plans (see 1986.); effective through Sept. 30, 1995.

1993 The secondary payer provision for disabled beneficiaries covered under large employer plans is effective through Sept. 30, 1998.

The secondary payer provision for beneficiaries with ESRD applies for all beneficiaries with end stage renal disease, not only those entitled to Medicare solely on the basis of it. The extension to include the first 18 months of an individual's entitlement on the basis of ESRD is effective through Sept. 30, 1998.

1997 An expanded set of options for the delivery of health care under Medicare, referred to as Medicare+Choice, is established. All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service program. In addition, most beneficiaries can choose instead to receive their Medicare benefits through one of the following Medicare+Choice plans: (1) coordinated care plans (such as health maintenance organizations, provider-sponsored organizations, and preferred provider organizations); (2) Medical Savings Account (MSA)/High Deductible plans (through a demonstration available for up to 390,000 beneficiaries); or (3) private fee-for-service plans. Except for MSA plans, all Medicare+Choice plans are required to provide the current Medicare benefit package (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. MSA plans provide Medicare benefits after a single high deductible is met, and enrollees receive an annual deposit in their Medical Savings Account. Transition rules for current Medicare HMO program also provided.

The provision making Medicare the secondary payer for disabled beneficiaries in large group health plans, previously scheduled to expire Sept. 30, 1998, made permanent.

The provision making Medicare secondary payer for the first 12 months of entitlement due to ESRD, which had been extended on a temporary basis (through Sept. 30, 1998) to include the first 18 months of entitlement, has been extended, permanently, to include the first 30 months of entitlement on the basis of ESRD.

Hospital Insurance

1965 In each benefit period, inpatient hospital services, 90 days. Includes semiprivate accommodations, operating room, hospital equipment (including renal dialysis), laboratory tests and X-ray, drugs, dressings, general nursing services, and services of interns and residents in medical osteopathic or dentistry training. Inpatient psychiatric hospital care limited to 190-day lifetime maximum. Outpatient hospital diagnostic services. Post-hospital extended-care services, 100 days (including physical, occupational, and speech therapy). Post-hospital home health services, 100 visits. Deductible and coinsurance provisions (see table 2.C1).

1967 Lifetime reserve of 60 additional days of inpatient hospital services. Outpatient hospital diagnostic services transferred to SMI.

1972 Services of interns and residents in podiatry training.

1980 Unlimited home health visits in a year. Requirement for prior hospitalization eliminated. Home health services provided for up to 4 days a week and up to 21 consecutive days.

	Alcohol detoxification facility services.
1981	Part A coinsurance is based on the deductible for the calendar year in which services are received rather than the deductible in effect at the time the beneficiary's spell of illness began, starting in 1982.
	Alcohol detoxification facility services eliminated.
1982	Beneficiaries expected to live 6 months or less may elect to receive hospice care benefits instead of other Medicare benefits. May elect maximum of two 90-day and one 30-day hospice care periods, effective Nov. 1, 1983, to Oct. 1, 1986.
1984	For durable medical equipment provided by home health agencies, the payment amount is reduced from 100 percent of costs to 80 percent of reasonable charges.
1986	Set the Part A deductible for 1987 at $520 with resulting increases in cost sharing. Increased the Part A deductible annually by the applicable percentage increase in the hospital prospective payment rates.
	Hospice care benefit (enacted in 1982) made permanent.
1987	Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).
1988	Enrollee pays annual hospital deductible (set at $560 for 1989) and Medicare pays balance of covered charges, regardless of the number of days of hospitalization (except for psychiatric hospital care, which is still limited by 190-day lifetime maximum).
	The number of days in a skilled nursing facility changed to 150 per year. Deletes the requirement for a prior hospital stay of 3 or more consecutive days.
	Expands home health care to provide care for less than 7 days per week and up to 38 consecutive days.
	Hospice care extended beyond 210 days when enrollee is certified as terminally ill.
	All 1988 provisions became effective Jan. 1, 1989.
1989	The spell of illness and benefit period coverage of laws prior to 1988 return to the determination of inpatient hospital benefits in 1990 and later. After the deductible is paid in benefit period, Medicare pays 100 percent of covered costs for the first 60 days of inpatient hospital care. Coinsurance applies for the next 30 days in a benefit period.
	The requirement for a prior hospital stay of 3 or more consecutive days is reinstated for skilled nursing facility services. Coverage returns to 100 days post-hospital care per spell of illness with a daily coinsurance rate in effect for days 21 through 100.
	Home health services return to a limit of 21 consecutive days of care. Provision providing for home health care for fewer than 7 days per week continued due to a court decision.
	Hospice care is returned to a lifetime limit of 210 days.
1990	Hospice care is extended beyond 210 days when enrollee is certified as terminally ill.
1997	Home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled nursing facility stay. The cost to the SMI Trust Fund of the transferred services will phase in over a 6-year period (that is, the HI Trust Fund will transfer funds to the SMI Trust Fund during that period).
	Limits on the number of hours and days that home health care can be provided have been clarified. "Part-time" now defined as skilled nursing and home health aide services (combined) furnished any number of days per week, for less than 8 hours per day and 28 or

fewer hours per week. "Intermittent" now defined as skilled nursing care provided for fewer than 7 days each week, or less than 8 hours each day (combined) for 21 days or less.

Hospice benefit periods are restructured to include two 90-day periods, followed by an unlimited number of 60-day periods.

Medicare coverage provided for a number of prevention initiatives, most of which covered under SMI program. HI program affected mainly by two of the initiatives:

Annual prostate cancer screening for male beneficiaries aged 50 or older, effective Jan. 1, 2000; and (2) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries age 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances.

Supplementary Medical Insurance

1965 Physician and surgeon services. In-hospital services of anesthesiologists, pathologists, radiologists, and psychiatrists. Limited dental services. Home health services, 100 visits in calendar year. Other medical services including various diagnostic tests, limited ambulance services, prosthetic devices, rental of durable medical equipment used at home (including equipment for dialysis), and supplies used for fractures. For deductible and coinsurance provisions, see table 2.C1.

Beginning in 1966, the beneficiary pays a $50 deductible, with a 3-month carryover provision.

1967 Outpatient hospital diagnostic services transferred from HI. Includes physical therapy services in a facility. Purchase of durable medical equipment.

1972 Physical therapy services furnished by a therapist in his or her office or individual's home (calendar year limit of $100). Chiropractor services (limited to manual manipulation of the spine). Outpatient services include speech pathology services furnished in, or under arrangements with, a facility or agency. Services of a doctor of optometry in furnishing prosthetic lenses.

Beginning in 1973, the beneficiary pays a $60 deductible.

1977 Services in rural health clinics.

1980 Home health services. Deductible applicable to home health services is eliminated, effective July 1, 1981.

Facility costs of certain surgical procedures performed in freestanding ambulatory surgical centers.

Increase in annual limit for outpatient therapy from $100 to $500.

Recognizes comprehensive outpatient rehabilitation facilities as Medicare providers.

1981 Beginning in 1982, the beneficiary pays a $75 deductible, with the carryover provision eliminated.

1984 Hepatitis B and pneumococcal vaccines and blood clotting factors and necessary supplies are included as Part B benefits. Debridement of mycotic toenails is limited.

For outpatient physical therapy services, includes services of a podiatrist. For outpatient ambulatory surgery, includes services of a dentist and podiatrist furnished in his or her office.

1986 Includes vision care services furnished by an optometrist.

For occupational therapy services, includes services furnished in a skilled nursing facility (when Part A coverage has been exhausted), in a clinic, rehabilitation agency, public health agency, or by an independently practicing therapist.

Includes outpatient immunosuppressive drugs for 1 year after transplant and occupational therapy services providers in certain delivery settings.

For ambulatory surgical procedures performed in ambulatory surgical centers, hospital outpatient departments, and certain physician offices, the Part B coinsurance and deductible are no longer waived.

1987 Increases the maximum payment for mental health services and includes outpatient mental health services provided by ambulatory hospital-based or hospital-affiliated programs under the supervision of a physician.

Services provided by clinical social workers when furnished by risk-sharing health maintenance organizations/competitive medical plans, physician assistants in rural health manpower shortage areas, clinical psychologists in rural health clinics and community mental health centers, and certified nurse-midwives.

Prescription drugs used in outpatient immunosuppressive therapy.

Specifies in law that in order to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1988 Beginning Jan. 1, 1990, the beneficiary pays a $75 deductible and 20-percent coinsurance, but once out-of-pocket expenses for the deductible and coinsurance exceeds $1,370, Medicare pays 100 percent of allowable charges for remainder of year.

Beginning in 1991, Medicare pays 50 percent of the cost of outpatient prescription drugs above $600. When fully implemented in 1993, Medicare will pay 80 percent of prescription drug costs above a deductible which assumes that 16.8 percent of Part B enrollees will exceed the deductible.

Certain prescription drugs-immunosuppressive therapy and intravenous (IV) drugs that can be administered in a home setting will be covered in 1990 under the new prescription drug provision.

1989 Provisions enacted in 1988 and to begin in 1990 and 1991 are repeated and benefits are restored to levels in effect prior to Jan. 1, 1989.

Limits on mental health benefits eliminated in 1990. Coverage extended to services of clinical psychologists and social workers.

The annual payment limits of $500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to $750, for 1990 and later. (See 1980.)

1990 Beginning in 1991, routine mammography screenings are covered.

The Part B deductible is set at $100 in 1991 and subsequent years.

Beginning in 1992, physicians' services are reimbursed on a fee-schedule basis.

1993 Includes coverage of oral, self-administered anticancer drugs.

Lengthens the coverage period for immunosuppressive drugs after a transplant to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter.

The annual payment limits of $760 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to $900 for 1994 and later. (See 1989.)

1997 Home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled nursing facility stay. The cost to the SMI Trust Fund of the transferred services will phase in over a 6-year period, while the cost of the home health services will phase into the SMI premium over 7 years.

Coverage provided for a number of prevention initiatives, including (1) annual screening mammograms for female beneficiaries age 40 or older, with SMI deductive waived; (2)

screening pap smear and pelvic exam (including clinical breast exam) every 3 years or annually for beneficiaries at higher risk, with SMI deductible waived; (3) annual prostate cancer screening for male beneficiaries aged 50 or older, effective Jan. 1, 2000; (4) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances; (5) diabetes outpatient self-management training in nonhospital-based programs (previously covered in hospital-based programs only) and blood glucose monitors and testing strips for all diabetics (previously provided for insulin-dependent diabetics only), effective July 1, 1998; (6) procedures to identify bone mass, detect bone loss, or determine bone quality for certain qualified beneficiaries, at frequencies determined by the Secretary of HHS, effective July 1, 1998.

Beginning January 1999, an annual beneficiary limit of $1,500 will apply to all outpatient physical therapy services, except for services furnished by a hospital outpatient department. A separate $1,500 limit will also apply to outpatient occupational therapy services, except for services furnished by hospital outpatient departments. Beginning with 2002, these caps will be increased by the percentage increase in the Medical Economic Index. (See 1993.)

1999 The coverage period for immunosuppressive drugs after a transplant is lengthened to 44 months, for individuals who exhaust their 36 months of coverage in 2000. For those exhausting their 36 months of coverage in 2001, at least 8 more months will be covered. (The Secretary of HHS will specify the increase, if any, beyond 8 months.) For those exhausting their 36 months of coverage in 2002, 2003, or 2004, the number of additional months may be more or less than 8. (The Secretary will specify the increase for each of these years.) (See 1993.)

The annual payment limits of $1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services furnished by independent practitioners (that is, not by hospital outpatient department), are suspended for 2000 and 2001. (See 1997.)

Medicare Financing

Hospital Insurance Taxes

See table 2.A3.

Appropriations from General Revenues

1965 For HI costs attributable to transitionally insured beneficiaries.

For HI costs attributable to noncontributory wage credits granted for military service prior to 1957 (see table 2.A2).

For the SMI program, an amount equal to participant premiums.

1972 For cost of SMI not met by enrollee premiums.

1982 For HI costs attributable to beneficiaries having transitional entitlement based on Medicare-qualified federal employment.

1983 For HI taxes on noncontributory wage credits granted for military service (a) from the inception of HI program through 1983 and (b) on a current basis, annually, beginning in 1984 (see table 2.A2).

Participant Premiums

See also table 2.C1.

1965 SMI enrollee premium rate (originally $3 per month) to be established annually such as to pay one-half of program costs.

1972	SMI enrollee premium rate increase limited to rate of increase in OASDI cash benefits.
	HI premium (originally $33 per month) to be established annually. Only individuals not otherwise entitled to HI but desiring voluntary participation need to pay the HI premium.
1983	SMI enrollee premiums for July 1983, to Dec. 31, 1983, frozen at premium level of June 30, 1983. Premiums for Jan. 1, 1984, to Dec. 31, 1985, set to cover 25 percent of aged program costs.
1984	SMI enrollee premiums for Jan. 1, 1986, to Dec. 31, 1987, will be set to cover 25 percent of aged program costs. Increases in the SMI premium may not exceed the dollar amount of the Social Security cost-of-living adjustment.
1985	Extends through calendar year 1988 the requirement that SMI premiums be set to cover 25 percent of aged program costs and that increases in the SMI premium may not exceed the dollar amount of the Social Security cost-of-living adjustment.
1987	Extends through calendar year 1989 the provisions requiring that the SMI premium be set to cover 25 percent of aged program costs, prohibiting any increase in the premium if there is no Social Security cost-of-living adjustment, and continuing to hold beneficiaries harmless from Social Security check reductions as a result of a premium increase.
1988	Increases in the SMI premium may not exceed the dollar amount of the Social Security cost-of-living adjustments for 1989 and beyond.
1989	Extends through calendar year 1990 the requirement that SMI premiums be set to cover 25 percent of aged program costs.
1990	The SMI premium amounts are $29.90 in 1991; $31.80 in 1992; $36.60 in 1993; $41.10 in 1994; and $46.10 in 1995.
1993	SMI enrollee premiums for Jan. 1, 1996, to Dec. 31, 1998, will be set to cover 25 percent of aged program costs.
1997	The SMI premium is permanently set a 25 percent of program costs.
	Income from Taxation of OASDI Benefits
1993	The additional income tax revenues resulting from the increase in the taxable percentage applicable to OASDI benefits (an increase from 50 percent to 85 percent, see table 2.A31) are transferred to the HI Trust Fund.
	Interfund Borrowing
1981	See table 2.A6.
1983	See table 2.A6.

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